STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX **File No. 88195-001-SF**
Petitioner
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 21st day of April 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 28, 2008, XXXXX, authorized representative of her husband XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it on March 6, 2008. As required by section 2(2) of Act 495, the Commissioner conducts this external review as though it were an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner has health care coverage as an eligible dependent of his wife through her employment with the XXXXX Public School System under a self-funded plan that is administered by Blue Cross and Blue Shield of Michigan (BCBSM). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on March 17, 2008. Additional information was provided on March 31, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Community Blue Group Benefit Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On June 26, 2007, the Petitioner had emergency surgery on two fingers while in the State of XXXXX. The surgery took place at XXXXX Hospital, a facility that participates with a local Blue Cross and Blue Shield plan.

The surgery was provided by XXXXX, MD, a nonparticipating provider (i.e., he has not signed an agreement with BCBSM or a local Blue Cross and Blue Shield plan in XXXXX to accept an approved amount as payment in full for his services). Dr. XXXXX charged $16,550.00 for the surgery and related care and BCBSM paid $4,244.86 as its approved amount for his services. This left the Petitioner to pay the balance of $12,305.14.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on October 30, 2007, and issued a final adverse determination dated January 10, 2008.

III
ISSUE

Is BCBSM required to pay any additional amount for the surgery and related care provided to the Petitioner on June 26, 2007 and June 27, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner was admitted to XXXXX Hospital in XXXXX for emergency surgery following a significant injury to the index and middle fingers of his right hand. His BCBSM medical card was presented at his admittance. The emergency room staff summoned Dr. XXXXX, who was the

reconstructive hand surgeon on call.

The Petitioner says that he did not use a nonparticipating doctor by choice; he was required to use the surgeon on call at the time. He believed his insurance had been accepted when he was admitted and he was not informed about the participating status of Dr. XXXXX before the surgery. He believes that BCBSM should pay the full amount charged for his surgery since it was provided on an emergency basis.

BCBSM's Argument

BCBSM says that Section 4 of the certificate, *Coverage for Physician and Other Professional Services,* explains that it pays its "approved amount" for physician and other professional services -- the certificate does not guarantee that provider charges will be paid in full. Since Dr. XXXX does not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full. Nonparticipating providers are by definition also nonpanel providers.

The amounts charged by the surgeon and the amounts paid by BCBSM for the June 26, 2007 and June 27, 2007 care are set forth in this table:

Date of Service	Procedure Code	Amount Charged by Surgeon	BCBSM's Maximum Payment Amount	Amount Paid by BCBSM	Petitioner's Balance
06/26/07	99283	$ 450.00	$208.00	$ 208.00	$ 242.00
06/26/07	11044	$ 2,500.00	$ 750.00	$ 750.00	$ 478.78
06/26/07	11760	$1,800.00	$289.00	$289.00	$1,511.00
06/26/07	13131	$3,500.00	$1,892.86	$1,892.86	$1,607.14
06/26/07	15574	$8,000.00	$1,105.00	$1,105.00	$6,895.00
06/27/07	99238	$300.00	$150.00	$0.00*	$300.00
	Totals	$16,550.00		$ 4,244.86	$12,305.14

* BCBSM's approved amount of $150.00 was applied to the out-of-network deductible. The out-of-network deductible was waived for the procedures of June 26, 2007, because the services were for an emergency. The June 27, 2007, care, however, was not emergency treatment.

In determining the maximum payment level for each service, BCBSM says it applies a resource based relative value scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training, and medical practice. BCBSM says there is nothing in the certificate that requires it to pay more than its approved amount even if the care was provided for a life-threatening condition or even if there were no participating providers available.

BCBSM believes that it has paid the proper amount for the Petitioner's care by a nonparticipating provider and is not required to pay any additional amount.

Commissioner's Review

The certificate describes how benefits are paid. It explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for the covered service." According to the certificate, participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges. The certificate states on page 4.26:

> When you receive covered services from a nonpanel provider, you will be required to pay a nonpanel deductible and a copayment for most covered services….

The certificate also contains this caveat (on page 4.27):

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. After paying the provider, you should submit a claim to us. If we approve the claim, we will send payment to the subscriber.
>
> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment may be less than the amount charged by the provider.

BCBSM paid for the Petitioner's surgery of June 26, 2007, based on its full approved

amount for all procedures. No nonpanel deductible was applied because the care was provided on an emergency basis.

For the inpatient care provided on June 27, 2007, BCBSM approved its full maximum of $150.00 for the service and then applied this amount to the Petitioner's nonpanel deductible. This care was not considered emergent in nature and therefore, the nonpanel deductible was not waived

It is unfortunate that the Petitioner was in a situation where he was not able to use a participating surgeon. Nevertheless, BCBSM is correct: there is nothing in the terms and conditions of the Petitioner's certificate that requires it to pay more than its approved amount to nonparticipating providers, regardless of the circumstance.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

BCBSM's final adverse determination of October 26, 2007, is upheld.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.